Affidavit of Laurence V. Cronin **Exhibit HH**

Gracie Gunther
Senior Claim Manager

CIGNA Group Insurance
Life - Accident - Disability

March 22, 2006

Routing D212
12225 Greenville Ave.
Suite 1000
Dallas, TX 75243
Telephone 800-352-0611, Ext. 7170
Facsimile 860-731-3238
gracie.gunther@cigna.com

ESQUIRE DEPOSITION SERVICES
1700 PACIFIC AVE
SUITE 4750
DALLAS, TX 75201

RE:	Claimant	:	Hestal Lipscomb
	Policy Keys	:	SHD 985005
	Account Name	:	EDS
	Administered by	:	Life Insurance Company of North America

To Whom It May Concern:

Enclosed are the documents requested in your subpoena dated March 17, 2006. Should you have any questions, please feel free to contact me.

Sincerely,

Gracie Gunther

LINA-001

AO 88 (Rev. 11/91) Subpoena in a Civil Case

United States District Court

NORTHERN DISTRICT OF TEXAS

HESTAL LIPSCOMB,
Plaintiff,
v.

ELECTRONIC DATA SYSTEMS CORPORATION,
Defendant.

SUBPOENA DUCES TECUM

CASE NUMBER: 05-477 SLR

TO: Life Insurance Company of North America
12225 Greenville Avenue
Suite 1000
Dallas, TX 75243
ATTN: Gracie Gunther

☐ **YOU ARE COMMANDED** to appear in the United States District Court at the place, date, and time specified below to testify in the above case.

PLACE OF TESTIMONY	COURTROOM / DATE AND TIME

X **YOU ARE COMMANDED** to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

	DATE AND TIME
Esquire Deposition Services 1700 Pacific Avenue, Suite 4750 Dallas, TX 75201	Monday, April 3, 2006 at 10:00 a.m.*

X **YOU ARE COMMANDED** to produce and permit inspection and copying of the following documents at the place, date, and time specified below (list documents): **All documents identified on the attached Exhibit A.**
Attendance at the deposition will be waived if the deponent produces the requested documents on or before April 3, 2006.

PLACE	DATE AND TIME
Esquire Deposition Services 1700 Pacific Avenue, Suite 4750 Dallas, TX 75201	Monday, April 3, 2006 at 10:00 a.m.

☐ **YOU ARE COMMANDED** to permit inspection of the following premises at the date and time specified below.

PREMISES	DATE AND TIME

Any organization not a party to this suit that is subpoenaed for the taking of a deposition shall designate one or more officers, directors, or managing agents, or other persons who consent to testify on its behalf, and may set forth, for each person designated, the matters on which the person will testify. Federal Rules of Civil Procedure, 30(b)(6).

ISSUING OFFICER'S SIGNATURE AND TITLE (INDICATE IF ATTORNEY FOR PLAINTIFF)	DATE
Attorney for Plaintiff	March 17, 2006

ISSUING OFFICER'S NAME, ADDRESS AND PHONE NUMBER

Laurence V. Cronin (ID No. 2385), Smith, Katzenstein & Furlow LLP, 800 Delaware Avenue, P.O. Box 410, Wilmington, DE 19899 (302) 652-8400

(See Rule 45, Federal Rules of Civil Procedure, Parts C&D on Reverse)

PROOF OF SERVICE

SERVED	DATE	PLACE
SERVED ON (PRINT NAME)	MANNER OF SERVICE	
SERVED BY (PRINT NAME)	TITLE	

DECLARATION OF SERVER

I declare under penalty of perjury under the law of the State of Delaware that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____

DATE SIGNATURE OF SERVER

_____

_____

ADDRESS OF SERVER

Rule 45, Federal Rules of Civil Procedure, Parts C & D:

(c) Protection of Persons Subject to Subpoenas.

(1) A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing undue burden or expense on a person subject to that subpoena. The Court shall enforce this duty and impose upon the party or attorney in breach of this duty an appropriate sanction, which may include, but is not limited to, lost earnings and a reasonable attorney's fee.

(2)(A) A person commanded to produce and permit inspection and copying of designated books, papers, documents or tangible things or inspection of premises need not appear in person at the place of production or inspection unless commanded to appear for deposition, hearing or trial.

(B) Subject to paragraph (d)(2) of this rule a person commanded to produce and permit inspection and copying may, within 14 days after service of the subpoena or before the time specified for compliance if such time is less than 14 days after service, serve upon the party or attorney designated in the subpoena written objection to inspection or copying of any or all of the designated materials or of the premises. If objection is made, the party serving the subpoena shall not be entitled to inspect and copy the materials or inspect the premises except pursuant to an order of the Court. If objection has been made, the party serving the subpoena may, upon notice to the person commanded to produce, move at any time for an order to compel the production. Such an order to compel production shall protect any person who is not a party or an officer of a party from significant expense resulting from the inspection and copying commanded.

(3)(A) On timely motion, the Court shall quash or modify the subpoena if it

(i) fails to allow reasonable time for compliance,

(ii) requires a person who is not a party or an officer of a party to travel to a place more than 100 miles from the place where that person resides, is employed or regularly transacts business in person, except that, subject to the provisions of clause (c)(3)(B)(iii) of this rule, such a person may in order to attend trial be commanded to travel from any such place with the State in which the trial is held, or

(iii) requires disclosure of privileged or other protected matter and no exception or waiver applies, or

(iv) subjects a person to undue burden.

(B) If a subpoena

(i) requires disclosure of a trade secret or other confidential research, development, or commercial information, or

(ii) requires disclosure of an unretained expert's opinion or information not describing specific events or occurrences in dispute and resulting from the expert's study made not at the request of any party, or

(iii) requires a person who is not a party or an officer of a party to incur substantial expense to travel more than 100 miles to attend trial, the court may, to protect a person subject to or affected by the subpoena, quash or modify the subpoena or, if the party in whose behalf the subpoena is issued shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship and assures that the person to whom the subpoena is addressed will be reasonably compensated, the Court may order appearance or production only upon specified conditions.

(d) Duties in Responding to Subpoena.

(1) A person responding to a subpoena to produce documents shall produce them as they are kept in the usual course of business or shall organize and label them to correspond with the categories in the demand.

(2) When information subject to a subpoena is withheld on a claim that it is privileged or subject to protection as trial preparation materials, the claim shall be made expressly and shall be supported by a description of the nature of the documents, communications, or things not produced that is sufficient to enable the demanding party to contest the claim.

EXHIBIT A

DEFINITIONS

The term "document(s)" set forth in this request refers to all writings of any kind, including the originals and all nonidentical copies, whether different from the original by reason of any notation made on such copies or otherwise, including without limitation, correspondence; memoranda; notes; diaries; statistics; letters; materials; orders; directives; interviews; telegrams; minutes; reports; studies; statements; transcripts; summaries; pamphlets; books; interoffice and intraoffice communications; notations of any sort of conversations, telephone calls, meetings or other communications; bulletins; printed matter; teletype; telefax; worksheets; and all drafts, alterations, modifications, changed and amendments of any of the foregoing; graphic or aural recordings or representations of any kind including without limitation, photographs, charts, graphs, microfiche, microfilm, videotape, records, motion pictures; and electronic, mechanical, or electrical recordings or representations of any kind, including without limitation, tapes, cassettes, cartridges, discs, chips, electronic mail and records.

"STD" refers to short term disability.

"FMLA" refers to Family and Medical Leave Act.

"EDS" refers to Electronic Data Systems Corporation.

DOCUMENTS REQUESTED

1. All documents that refer or relate to Hestal Lipscomb's attempts to obtain either STD benefits or FMLA leave in 2004 while employed by EDS.

2. All documents that identify or disclose information about documents received by facsimile number 800-325-1016 on June 21, 2004. This request includes, but is not limited to, any

logs, activity reports, confirmations, computer printouts or other means of recording information about the documents received by facsimile at that number.

Rudeen, Kimberlee (Kim) 212

From: Rudeen, Kimberlee (Kim) 212
Sent: Wednesday, June 02, 2004 11:53 AM
To: 'tracey.eaddy@eds.com'
Subject: Hestal Lipscomb

ERISAdenialtoHR.doc (32 KB)

LINA-006

Kim Rudeen, FLMI, ACS
Sr. Case Manager
Dallas Claims Service Center

CIGNA Group Insurance
Life - Accident - Disability

June 2, 2004

Routing 212
12225 Greenville Ave
Ste 1000
Dallas, Texas 75243
Telephone 800.352.0611 ext. 6508
Facsimile 860.731.3511
Kim.rudeen@cigna.com

Electronic Data Systems
Tracey Eaddy

Re:	Claimant:	Hestal Lipscomb
	Employee ID:	01071260
	Policy #:	SHD 985005
	Employer:	Electronic Data systems
	Administered By:	Life Insurance Company of North America

Dear Tracey,

We have completed our review of the above Short Term Disability claim and regretfully, benefits have been denied. It was our determination that Hestal failed to provide medical information to support her time off work.

Hestal has been provided a detailed explanation of the denial, including appeal rights. Hestal must submit her request for appeal within 15 days of the date of this letter.

If either you or your employee has any questions, please contact me at 1.800.352.0611 ext. 6508. My normal office hours are 8:30am to 5:00pm Central Standard Time.

Sincerely,

Kim Rudeen, FLMI, ACS
Sr. Case Manager

LINA-007

CIGNA 001

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	0898
CONNECTION TEL	99726053343
CONNECTION ID	
ST. TIME	06/20 09:23
USAGE T	01'57
PGS. SENT	4
RESULT	OK

12225 Greenville Avenue Ste 1000
Dallas, TX 75243
Phone: 1.800.352.6593
Fax: 1.860.731.3511

Cigna Disability Management

Fax

To:	Symphuel Anderson	**From:**	Kim Rudeen
Fax:	972.605.3343	**Date:**	June 20, 2005
Phone:	N/A	**Pages:**	4 including cover sheet
Re:	Hestal Lipscomb	**Attn:**	

☑ **Urgent** ☐ **For Review** ☐ **Please Comment** ☑ **Please Reply** ☐ **Please Recycle**

•Comments:

Hello-

As per your request, these letters are being faxed to you.

Kim Rudeen

12225 Greenville Avenue Ste 1000
Dallas, TX 75243
Phone: 1.800.352.6593
Fax: 1.860.731.3511

Cigna Disability Management

Fax

To: Symphuel Anderson **From:** Kim Rudeen

Fax: 972.605.3343 **Date:** June 20, 2005

Phone: N/A **Pages:** 4 including cover sheet

Re: Hestal Lipscomb **Attn:**

☑ **Urgent** ☐ **For Review** ☐ **Please Comment** ☑ **Please Reply** ☐ **Please Recycle**

•Comments:

Hello-

As per your request, these letters are being faxed to you.

Kim Rudeen

Kim Rudeen, FLMI, ACS
Sr. Case Manager
Dallas Claims Service Center

CIGNA Group Insurance
Life · Accident · Disability

June 2, 2004

HESTAL LIPSCOMB
3111 W 2ND STREET
1ST FLOOR
WILMINGTON DE 19805

Routing 212
12225 Greenville Ave., Ste.1000
Dallas, Tx 75243
Telephone 1.800.352.0611 ext. 6508
Facsimile 860.731.3511
Kim.rudeen@Cigna.com

Re: Claimant: Hestal Lipscomb
Employee ID: 01071260
Policy Number: SHD 985005
Employer: Electronic Data Systems
Administered by: Life Insurance Company of North America

Dear Ms. Lipscomb,

This letter is in reference to your claim for Short-Term Disability benefits. The following information previously requested from you/your doctor has not been received to date:

- ✓ Confirmation of the surgical procedure you underwent
- ✓ medical information from Dr. Kraut to support your time off work
- ✓ your signed authorization to release medical information and proof of loss form

Under the EDS Short-Term Disability Plan, your medical provider must provide documentation and any related necessary information that validates your medical inability to work, within 15 days of when your claim is reported, except where prohibited by law.

We have attempted to contact you by phone on 5/27/04 and 6/1/04, without response. On 5/27/04 we requested that Dr. Kraut provide us with the medical information regarding your treatment and reason for being off work. As of this writing we have not received any medical information to support your time off work, nor have we received your signed authorization to allow your doctor to respond to our request for information. Without medical information to support your time off work we are unable to consider any benefits payable on your claim and we must deny your request for benefits.

If you feel that this determination is incorrect, we will review any evidence you may wish to submit which will support your claim. If the information warrants, we may alter our determination.

You may request a review of this denial by writing to the attention of the representative signing this letter at:

Life Insurance Company of North America
12225 Greenville Ave.
Suite 1000
Dallas, TX 75243

The written request for review must be sent within 15 days of the date of this letter and state the reasons why you feel your claim should not have been denied. Please include any medical evidence, which

supports your continuting disability. Medical evidence includes, but is not limited to physician's office notes, hospital records, consultation reports, test result reports, therapy notes, physical and/or mental limitations (i.e. Functional Capacities Testing), treatment history including a list of prescribed drugs along with their dosages, frequency and response, etc. Please be advised that you are entitled to access of relevant documents, records, and other information that was used to make this determination. This information will be supplied upon your request.

Under normal circumstances, you will be notified in writing of the final decision within 45 days of the date your request is received. If there are special circumstances requiring delay, you will be notified of the reason for delay within 45 days of the date your request is received. A final decision will be made no later than 90 days after your request is received.

Your leader will discuss with you any reimbursement to EDS for disability benefits that were over paid to you as a result of the denial or closure of your claim.

This letter should not be construed as a waiver of any rights or defense under the plan. This determination has been made in good faith and without prejudice under the terms and conditions of the plan, whether or not specifically mentioned herein. Should you have any information, which would prove contrary to our findings, please feel free to submit it to us. We will be pleased to review any supportive information you wish to submit.

Although your STD claim has been denied, you may be eligible for leave under the Family Medical Leave Act (FMLA). If eligible, you will receive information under separate cover from CIGNA Leave Solutions. If you have questions regarding your FMLA eligibility, please contact CIGNA Leave Solutions at (800) 778-8458.

Should you have any questions, please feel free to contact me at 1.800.352.0611 ext. 6508. My normal office hours are Monday through Friday, 8:30 to 5:00, Central Standard Time.

Thank you,

Kim Rudeen, FLMI, ACS
Sr. Case Manager

Charlene Crowder
Case Manager
Dallas Claims Service Center

CIGNA Group Insurance
Life · Accident · Disability

May 4, 2004

LIPSCOMB, HESTAL
3111 WEST 2ND STREET
1ST FLOOR
WILMINGTON, DE 19805

Routing 212
12225 Greenville Ave
Ste 1000
Dallas, Texas 75243
Telephone 800.352.0611 ext. 5686
Facsimile 860.731.3511
Charlene.Crowder@cigna.com

Re:

Claimant:	LIPSCOMB, HESTAL
Employee ID:	01071260
Policy Number:	SHD 985005
Employer:	Electronic Data Systems
Administered by:	Life Insurance Company of North America

Dear Ms. Lipscomb

We acknowledge receipt of your claim for Short Term Disability (STD) benefits. We will do everything we can to ensure your satisfaction and to make this process as simple as possible during this time.

In order to make a determination about short-term disability benefits, we must obtain medical information to verify your diagnosis and current functional abilities, and your current treatment plan. We are requesting information from Dr. Johnathan Kraut. In the event that we are unable to obtain this medical information, it is your responsibility to provide us with the required information. Please contact your physicians and ask that they cooperate with us and respond to our requests as soon as possible. If we do not receive the information needed by 05/19/2004, we will make a decision based on the information in our file.

To expedite the processing of your claim, please sign and fax the enclosed Disclosure Authorization and EDS Reimbursement Agreement to us as soon as possible at 860 731 3511. We may be unable to obtain medical information relevant to your claim without a signed Disclosure Authorization form. If we cannot get this information, we cannot make a determination on your claim and any potential benefit payments may be delayed or denied. We also ask that you review and sign the enclosed claim form (if any information is missing or incorrect, please change it on the form) and return it to us at the address listed above.

Please be aware that if you are employed in California, New Jersey, or Rhode Island, you are entitled to and are expected to apply for State Disability Benefits directly with the state. We will assume that you are receiving disability benefits under the state program unless you provide us with proof that your claim under the state plan has been denied because you are not eligible for benefits. We will appropriately reduce any benefit payable under the EDS Short-term disability plan by the calculated state disability entitlement. For information regarding how to file for disability benefits under the CA, NJ or RI state disability plan, please see the EDS benefits website.

If you are employed in Hawaii or New York, you do not need to file for benefits under the state disability plan. CIGNA Group Insurance will handle claims under the state plans for employees working in Hawaii and New York, and will coordinate any payments under the state plan with any benefits payable under the EDS STD plan.

Task | Contents | Notes (0/0)

Task: Phone Contact

Start Date: 05/27/2004 **Due Date:** 05/28/

Details

REDACTED

Name	HESTAL LIPSCOMB			**DOB**	0
Account Name	ELECTRONIC DATA SYSTEMS	**Account #**	SHD0985005	**Incurred Date**	0
Claim Manager	Charlene Crowder	**Incident #**	1191446	**Claim Eff Dt-Status**	0 P
Type*	Outgoing	Date	05/27/2004 03:27 PM	User ID	Sha
First Name	tracey	Last Name	eaddy		
Role	Employer	Specify Other	supervisor		
Call Reason*	Employer Inquiry	Action Taken	Issue Resolved		

Call Summary*

05/27/2004 1522 CST tct Supervisor Tracey Eaddy 302.454.7622, asked for JD ar requirements mail room clerk, opens mail, sorts, metering of mail, delivers ma usually envelopes. sedentary to light duty. States that they can accommodate t work arrangements if necessary. NCM to fu after medical obtained. Sharon Reeve

Last Changed User: Sharon Reeves Last Changed Date: 05/28/2004 09

Active Contents

Type	Due Date	Created By	Assigned To	Name
STD	04/29/2004	Charlene Crowder	LIPSCOMB,HESTAL	REDACTED

Status: Completed **Assigned To:** Sharon Reeves Creat

Task | Contents | Notes (0/0)

Task: Provider Contact

Start Date: 05/27/2004 **Due Date:**

Details

REDACTED

Name	HESTAL LIPSCOMB			**DOB**	0
Account Name	ELECTRONIC DATA SYSTEMS	**Account #**	SHD0985005	**Incurred Date**	0
Claim Manager	Charlene Crowder	**Incident #**	1191446	**Claim Eff Dt-Status**	0 P

Contact - Interview Documentation - Obj. Findings - Treatment - Functionality - Re

Contact Information

☒ First Phone Call	Result	Left Message - Answering Machine	Date	05/27/2004 03:12 PM	User	Sha
☐ Second Phone Call	Result		Date		User	
☐ Generate Letter/Fax			Date		User	
☐ Burden of Proof Letter Sent			Date		User	
☐ Incoming Call			Date		User	
☐ Mail Received			Date		User	

Contact Comments:

05/27/2004 1511 CST tct Dr. Johnathan Kraut surgical dept 302.428.6496 lvmm regarding dx, type of surgery, tx plan and rtw status. NCM to fu w/i 48 worki sharon Reeves RN

Interview Documentation

Provider First Name	JOHNATHAN	Provider Last Name	KRAUT	Provider Spe	
Contact First Name		Contact Last Name		Contact Role	
Primary ICD Code		Primary ICD Description			

Comments

Secondary ICD Code | Secondary ICD Description

Comments

ICD Code 3 | ICD Code 3 Description

Comments

ICD Code 4 | ICD Code 4 Description

Comments

ICD Code 5 ICD Code 5 Description
Comments

Objective Findings

- Physical Exam Findings
- Test Results
- Provider Observations

Comments

Treatment Information

Medication (1)		Dosage (1)	Frequency (1)
Medication (2)		Dosage (2)	Frequency (2)
Medication (3)		Dosage (3)	Frequency (3)
Medication (4)		Dosage (4)	Frequency (4)
Medication (5)		Dosage (5)	Frequency (5)

Current Treatment Plan

Treatment Frequency

Future Treatment Plan

Copy to Med/Voc Folder	Date of Surgery		Type of Surgery
Copy to Med/Voc Folder	Date of Surgery		Type of Surgery
Copy to Med/Voc Folder	Date of Surgery		Type of Surgery

Comments

Last Office Visit
Next Office Visit

Functionality Job/Occ Requirements and RTW

Claimant Job/Occ Requirements and Expected Duration

Additional Information

Provider's Estimated RTW Date

Copy to Claim File

Referral Information

First Name
Specialty
Number
Remarks
Last Name
Provider Referral Date
Ext.

First Name
Specialty
Number
Remarks
Last Name
Provider Referral Date
Ext.

First Name
Specialty
Number
Remarks
Last Name
Provider Referral Date
Ext.

Last Changed User Sharon Reeves Last Changed Date 06/02/20

Active Contents

Type	Due Date	Created By	Assigned To	Name
STD	04/29/2004	Charlene Crowder	LIPSCOMB,HESTAL	REDACTED

Status: Completed **Assigned To:** Sharon Reeves

Task | Contents | Notes (0/0)

Task: Claimant Contact

Start Date: 05/03/2004 **Due Date:** 05/

Details

REDACTED

Name	HESTAL LIPSCOMB			**DOB**	0
Account Name	ELECTRONIC DATA SYSTEMS	**Account #**	SHD0985005	**Incurred Date**	0
Claim Manager	Charlene Crowder	**Incident #**	1191446	**Claim Eff Dt-Status**	0 P

Contact Information - Interview Documentation - Spouse Information

Contact Information

☒ First Phone Call					
Result	Left Message - Answering Machine	Date	05/27/2004 03:09 PM	User ID	Sha
☒ Second Phone Call					
Result	Left Message - Answering Machine	Date	06/01/2004 11:17 AM	User ID	Sha
☐ Generate Letter/Fax		Date		User ID	
☐ Incoming Call		Date		User ID	
☐ Mail Received		Date		User ID	

Contact Comments

```
05/27/2004 1509 CST tct ee  302.655.8973 lvmm for cb.  NCM to fu w/i 48 workir
Sharon Reeves RN

06/01/2004 1117 CST tct ee  above no. lvmm for cb. If no response w/i 24 worki
have CM send contact letter. Sharon Reeves RN

06/02/2004 No response from ee will have CM send contact letter to obtain medi
Reeves RN
```

Interview Documentation

Primary Diagnosis/Symptoms/Co-Morbid Conditions

Treating Physicians/Treatment Frequency/Current Treatment Plan/Hospitalization

Functionality/Job Duties/Set Expectations

Spouse Information

First Name		MI	Last Name
SSN		Date of Birth	
Is Spouse Employed?		If Employed	
Date of Birth of Youngest Dependent			

Other Income Benefits

Comments

Last Changed User | Sharon Reeves | Last Changed Date | 06/02/2004

Active Contents

Type	Due Date	Created By	Assigned To	Name
STD	04/29/2004	.	Charlene Crowder	LIPSCOMB,HESTAL REDACTED

Status: Completed **Assigned To:** Sharon Reeves Cr

LINA-018

Task | Contents | Notes (0/1)

Task: Intake

Start Date: 04/20/2004 ***Due Date:***

Details

Requestor Name	TRACEY EADDY	**Phone**	(302)454-7622
Employee Name	HESTAL LIPSCOMB	**Phone**	(302)655-8973
Account Name	ELECTRONIC DATA SYSTEMS (EDS)	**Claim Type**	STD

Requestor Information - Employee Information - Employer Information
Supervisor Information - Condition Information - Medical Information - Information f

Requestor Information

Format	☐ After Hours ☐ E-Mail ☐ Fax ☐ Mail ☒ Telephonic ☐ Web		
Received Date	04/30/2004		
Role	Employer		
First Name	TRACEY		
Last Name	EADDY		
Phone Number	Type: Other Phone	Number	(302) 454-7622

Employee Information

REDACTED

Employee ID Number	MZ8S22		
Date of Birth	REDACTED	Age	40
Prefix Name			
First Name	HESTAL		
Middle Initial			
Last Name	LIPSCOMB		
Suffix Name			
Home Address	Added		
Address Line 1	3111 W. 2ND STREET		
Address Line 2	1ST FLOOR		
Zip Code	19805		
City	WILMINGTON		
State/Province	DELAWARE		
Country	United States		

	Type	Number
Phone Number 1	Home	(302) 655-8973
Phone Number 2	Work	(302) 454-7622
Phone Number 3		
Phone Number 4		

E-Mail Address

Gender ☒ Female ☐ Male

Marital Status ☐ Married ☐ Partner ☒ Single ☐ Unknown ☐ Unreported ☐ Wido
Preferred Language English

Employer Information

Account Name ELECTRONIC DATA SYSTEMS (EDS)
☐ WC/FROI Indicator
☒ FMLA Indicator
Work Location Fed OK
Address Line 1 248 CHATMAN RD.
Address Line 2 STE 100
Zip Code 19702
City NEWARK
State / Province DELAWARE
Country United States

Supervisor Information

First Name TRACEY
Last Name EADDY
Phone Number (302) 454-7622 Ext.
E-Mail Address TRACEY.EADDY@EDS.COM

Description of Job Duties
☒ Typing/Computer Work
☒ Sitting
☐ Standing
☐ Walking
☐ Supervise/Manage
☐ Stooping
☐ Crawling
☐ Operating Heavy Equipment
☐ Writing(manual)
☐ Repetitive Motion
☐ Phone
☐ Bending
☐ Driving
☐ Climbing
☐ Pushing
☐ Carrying
☐ Lifting
☐ Other

Occupation Category 05 - Office and Clerical
Job Title MAIL ROOM CLERK
Date of Hire 07/29/2002
Last Day Worked 04/28/2004
First Day Missed From Work** 04/29/2004
Expected Time Out of Work
Expected RTW Date
Other Employment? No
Applied for or Receiving Other Benefits? No

Condition Information

Condition ☒ Illness ☐ Injury ☐ Pregnancy
Diagnosis or Description of Medical Condition:
GRANDULURE TUMOR

LINA-020

Is Condition Related to Work Activities?	No
Claim Type	STD

Illness/Injury Information

Date Accident Happened or Symptoms first Appeared	03/01/2004
Past/Recurrent Condition?	Yes
Other Medical Conditions:	
Did Condition Result in Death?	
Time of Injury	
Body Section	
Side	
Body Part	
Nature of Injury	
Cause of Incident	
Place of Illness/Injury	☐ Auto ☐ Home ☒ Other
State Accident Occured In	
Describe What Happened:	

Place Description	
Address Line 1	
Address Line 2	
City	
State/Province	
Country	United States

Witness Information

Were There Witnesses?	

Medical Information

Hospital or Clinic?	No

Surgery Information

Surgery Scheduled or Performed?	Yes
Date of Surgery	04/29/2004
Type of Surgery	

Provider Information

First Name	JOHNATHAN
Last Name	KRAUT
Address Line 1	501 W. 14TH ST.
Address Line 2	
Zip Code	19801
City	

LINA-021

State / Province	WILMINGTON
Country	DELAWARE
Phone Number	United States
E-mail Address	(302) 428-6496 Ext.
Provider Specialty	
Date of First Treatment	
Date of Most Recent Treatment	04/07/2004
Date of Next Scheduled Treatment	

Date Unable to Work According to Provider			
Primary ICD Code			
Secondary ICD Code		Description	
ICD Code 3		Description	
ICD Code 4		Description	
ICD Code 5		Description	
		Description	

Information from Employer

Employment Status: Active Employee

Job Characteristics

☒ Exempt	or	☒ Non-Exempt
☒ Full-Time	or	☐ Part-Time
☐ Management	or	☒ Non-Management
☐ Supervisory	or	☒ Non-Supervisory
☐ Union	or	☒ Non-Union
☒ Salary	or	☐ Hourly

Eligible for Overtime?	Yes
Receive Commissions	No
☒ Eligible for Bonus?	

Work Shift Information

Shift Schedule	☒ Standard ☐ Days Vary ☐ Times Vary
Work Week	☐ Su ☒ M ☒ Tu ☒ W ☒ Th ☒ F ☐ Sa
Start Time	8 : 00 AM
End Time	5 : 00 PM
Total Hours Worked Per Week	40
Details	
Date of Last Change in Earnings	04/01/2004
Compensation Amount/Frequency	$20,000.16 Annually
	Annual Salary: 20000.16 -- Monthly: 1666.68 -- Weekly: 384.62

Did employee receive a pay increase at last review?

In the past 12 months, has the employee been out of work more than 5 consecutive days,

excluding holidays and vacation?

In the past 12 months, has the employee received any of the following?
- ☐ Attendance Warnings
- ☐ Performance Warnings
- ☐ Conduct Warnings
- ☐ Other

Hours Worked Last Day	8
First Day Missed From Work (ER)**	04/2
Has Employee Returned to Work	No

Insurance Information

Healthcare Insurance Provider	Aetna
Life Insurance with Cigna?	
STD Effective Date	
STD Contribution	
Did the Employee purchase a Buy-Up Coverage for STD?	
Employer-Calculated Blended Contribution	0.00 %

☐ Requested Job Description From Employer

Incident Number: 1191446

Comments:

Early Notice ID	000000000
CHC Eligibility Source	
CHC Data Source	
CHC Medical Product Type	
CIGNA Behavioral Type	
CHC Well Aware	Unknown

Last Changed User: Timothy Wilson Last Changed Date: 04/3

Active Contents

Type	Due Date	Created By	Assigned To	Nan
STD	04/29/2004	Charlene Crowder	LIPSCOMB,HESTAL	REDACTED

Status: Completed **Assigned To:** Timothy Wilson

P. 1

* * * COMM. ION RESULT REPORT (MAY. 7. 20.. 1 54AM) * * *

FAX HEADER: CIGNA DALLAS

TRANSMITTED/STORED : MAY. 7. 2004 10:53AM
FILE MODE OPTION ADDRESS RESULT PAGE

MEMORY TX 913024286403--47687 OK 1/1

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL E-2) BUSY
E-3) NO ANSWER E-4) NO FACSIMILE CONNECTION

Facsimile Transmission Cover Sheet

CIGNA Group Insurance
Life • Accident • Disability

Transmit to FAX number	Date	Time	Total number of pages
302-428-6403	05/07/04	(including this sheet):	1

To

Name
Dr. Emily Jane Penman
Company

Phone
302-428-4413
Address

From

Name
Charlene Crowder
Department
Fax: 1.800.325.7016
Phone
(800) 352-0611, ext. 5686
Address
D212
12225 Greenville Ave
Suite 1000
Dallas, Texas 75243

REDACTED

Patient: Hestal Lipscomb DOB:

We are currently evaluating a Short Term Disability claim for the above named patient. In order to make a determination on extending your patients disability benefits we need the following please:

What is the current diagnosis? What was the first date of treatment for current diagnosis?

What is the first day the doctor certified the patient disabled? Hospitalized/ dates: _____

What are the current limitations/restrictions that prevent or prevented the patient from working?

Please send copies of all current test results and office notes from April 2004 through the present.

What are the current treatment plan goals and when do you anticipate a full time return to work?

What is next office visit?

Please list medications and test to be done.

Thank you for your cooperation in this matter. Should you have any other further questions, please do not hesitate to contact me. To expedite the processing of the claim, we ask that you respond to our request via facsimile 1.800.325.7016.

Sincerely,
Charlene Crowder
Case Manager

CONFIDENTIALITY NOTICE: If you have received this facsimile in error, please immediately notify the sender by telephone at the number above. The documents accompanying this facsimile transmission contain confidential information. This information is intended only for the use of the individual(s) or entity named above. Thank you for your compliance.

[ ] Acknowledgment Requested

To Fax a reply, dial: (800) 325.7016

LINA-025

Facsimile Transmission Cover Sheet

CIGNA Group Insurance
Life · Accident · Disability

Transmit to FAX number	Date	Time	Total number of pages
302-428-6403	05/07/04	(including this sheet) :	1

To

Name
Dr. Emily Jane Penman
Company
Phone
302-428-4413
Address

From

Name
Charlene Crowder
Department
Fax: 1.800.325.7016
Phone
(800) 352-0611, ext. 5686
Address
D212
12225 Greenville Ave
Suite 1000
Dallas, Texas 75243

REDACTED

Patient: Hestal Lipscomb DOB:

We are currently evaluating a Short Term Disability claim for the above named patient. In order to make a determination on extending your patients disability benefits we need the following please:

What is the current diagnosis? What was the first date of treatment for current diagnosis?

What is the first day the doctor certified the patient disabled? Hospitalized/ dates: _____

What are the current limitations/restrictions that prevent or prevented the patient from working?

Please send copies of all current test results and office notes from April 2004 through the present.

What are the current treatment plan goals and when do you anticipate a full time return to work?

What is next office visit?

Please list medications and test to be done.

Thank you for your cooperation in this matter. Should you have any other further questions, please do not hesitate to contact me. To expedite the processing of the claim, we ask that you respond to our request via facsimile 1.800.325.7016.

Sincerely,
Charlene Crowder
Case Manager

LINA-026

[ ] Acknowledgment Requested

To Fax a reply, dial : (800) 325.7016

Short Term Disability

Proof of Loss

CIGNA Group Insurance
Life • Accident • Disability

Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

FRAUD WARNING: Any Person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purposes of misleading, information concerning any material fact, commits a fraudulent insurance act. For residents of the following states, please see the reverse side of this form: California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas, or Virginia.

EMPLOYEE INFORMATION

Name of Employee (Last, First, Middle):	Date of Birth:	Incident #:	Sex:
LIPSCOMB, HESTAL	REDACTED	1191446	☐ Male ☒ Female ☐ Unknown

Address (Street, Apt):			
3111 W. 2ND STREET, 1ST FLOOR			
City:	**State:**	**Zip Code:**	**Telephone No.:**
WILMINGTON	DE	19805	(302) 655-8973

Please describe your condition:
GRANDULURE TUMOR has an open incisim & will go back to Dr. on Monday.

PLEASE COMPLETE SECTIONS A, B, OR C - AND THE REMAINDER OF THE APPLICATION

A

Is this an injury?	Date of Injury:	Time of Injury:	Is this work related?
☐ Yes ☒ No ☐ Unknown			☐ Yes ☐ No ☐ Unknown

Describe the cause of injury:

B

Is this an illness?	Date of Illness:	Is this work related?
☒ Yes ☐ No ☐ Unknown	03/01/2004	☐ Yes ☒ No ☐ Unknown

Describe the cause of illness:

C

Is this an pregnancy?	Delivery/Due Date:	Delivery Method:	Were there complications?
☐ Yes ☒ No ☐ Unknown			☐ Yes ☐ No ☐ Unknown

Describe the complications:

Are you currently losing time from work?	If yes, what specifically prevents you from working?	
☐ Yes ☐ No ☐ Unknown		
Last Day Worked: 04/28/2004 # hours worked: 8.00	**Date first unable to work:** 04/29/2004	**Date you plan to return to work:**
Have you had the same or similar condition in the past? ☒ Yes ☐ No ☐ Unknown	If yes, when did it occur (dates)?	Please describe:

Please list any states in which you may be liable for filing tax returns:
DE

LINA-027

Are you receiving any other income or benefits? If so, please complete the following.

Benefit Type	Gross Weekly Amount	Date Began	Paid thru Date

Dr. Emily Jane Pinman (302) 428-1112

Integrated Disability Management Disclosure Authorization for Disability and Workers' Compensation

Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York
ACE American Insurance Company
ESIS, Inc.

FRAUD WARNING

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the reverse side of this form: *California, Colorado, District of Columbia, Florida, Maryland, New Jersey, New York, Pennsylvania, Oregon or Virginia.*

Claimant's Name (Please Print): _____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give the companies named below (Companies) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my plan administrator sponsors both a disability plan underwritten or administered by Companies and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Companies or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for disability and/or workers' compensation benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Companies. The information obtained will not be disclosed to anyone EXCEPT: a) reinsuring companies; b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c) fraud or overinsurance detection bureaus; d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Companies under its Social Security Assistance Program and employers involved in return to employment discussions; e) for audit or statistical purposes; f) as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drug or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Companies to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Companies may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative: _____ Date: _____

Relationship,
if other than Claimant: _____ Claimant's Social Security Number: _____

Companies: Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York
ACE American Insurance Company
ESIS, Inc.

LINA-028

CIGNA Group Insurance Disability Management Solutions

CIGNA

Frequently Asked Questions For Claimants

Intake Questions

What happens after I file my claim?

After you file your claim, your case manager may contact you by phone to discuss the claim process, or in some cases, contact you by letter. If your disability absence is planned for the future, you will receive a "future claim letter" acknowledging your anticipated disability and asking you to contact us on your last day of work before your disability begins. You will be asked to sign a release of information for your doctor (which you can download from our website www.CIGNA.com), so we can obtain your medical reports.

Your employer will be contacted for eligibility information and a description of your job requirements to help us determine if you are eligible for benefits and how long your absence may be. Our goal is to help you return to a productive work environment and to assist you in the process.

Who contacts my doctor? Do I need to call my doctor?

Depending on the type of disability claim, we may need medical information from your doctor. If so, you should contact your doctor's office and ask them to send us your medical information. During the first three to five business days after we receive your claim, your case manager will also attempt to reach your doctor to obtain medical information.

What will I receive in the mail from CIGNA Group Insurance, and when?

You should receive an acknowledgement packet with a copy of your claim form, a release of information and this FAQ in a week to ten (10) days. To expedite your claim, CIGNA Group Insurance asks that you make any corrections to your claim form and return it along with the signed release of information form, to your case manager. If you do not receive your claim form in 10 days, you should contact your case manager to obtain another copy.

How long will it take to make a decision about my claim?

Once we get the necessary information from your employer and your doctor, we will reach a decision on your claim as soon as possible, generally within 10 days for short-term disabilities and 25 days for long-term disabilities.

What will delay a decision on my claim?

A delay in receiving any of the following can delay our decision and consequently delay payment to you:

- Verification of your eligibility for benefits from your employer;
- A signed authorization to release information from you; or
- Medical information from your doctor

CIGNA Group Insurance Disability Management Solutions

CIGNA

Frequently Asked Questions For Claimants

Payment Questions

How much money will I get paid? How often will I get paid?

This is different for every employer's benefit plan. Disability benefits may be a percentage of your weekly or monthly income, or a set amount. Your case manager or Human Resources representative can tell you what benefits you are entitled to receive, and when your benefits start. Depending on your employer's benefit policy your checks may be issued on a weekly, bi-weekly, or monthly basis. Checks are generally issued at the end of each payment period.

For example, if your benefits are due to begin on July 15 and are paid on a weekly basis, you should receive your first check for the period of July 15 through July 21 on or around July 21. If your benefits are paid on a monthly basis, you should expect your first check for the period of July 15 through August 14 on or around August 14. Benefits will be issued in a similar manner for the duration of your claim. You can also check your employee benefits booklet or summary plan description to confirm your specific benefit amount, as well as any other income that would reduce your benefit amount.

How long will my benefits last?

It depends on your employer's benefit plan, on continuing evidence that your condition prohibits you from being able to work, and on evidence that you remain entitled to benefits. If your claim is approved, and if CIGNA Group Insurance issues your benefits, the approval letter will address the amount and duration of your benefits. If your employer issues your benefits, you'll be advised of the approval duration in the letter, however, you should also contact your local human resources department for the amount of your benefits.

Can I have direct deposit?

Direct deposit is available for fully insured long-term disability benefits as long as your bank has the capability to participate in direct deposit programs. It is not available for short-term disability benefits, or if your employer's long-term disability plan is administrative services only. If you wish to have your benefits directly deposited into your checking or savings account, you can contact your case manager and make this request. Once we receive your request, it may take 4 to 6 weeks to activate direct deposit. A form will be mailed to you for you to complete, and return to our office. Once received, your benefit payment method will be updated. If your employer issues benefits to you directly, then you would need to contact your local Human Resources representative for this option. In some cases, we may not be able to accommodate your request (i.e., if you are to return to work in a few days, this option may not be feasible).

Is my benefit taxable?

Your benefit or a portion of it may be taxable. If your employer pays the premiums for your disability benefits it may be taxable to you. If you pay the premiums on a post-tax basis it may not be taxed. If you and your employer share the cost of the premiums, the portion of the premium that is paid on a pre-tax basis may be taxable to you. Contact your Human Resources department and your tax advisor for more information about the tax effects of your specific benefit plan.

Agreement to Reimburse Overpayment of Disability Benefits

EDS employees applying for Disability Benefits through CIGNA are required to sign the *Agreement to Reimburse Overpayment of Disability Benefits* below ("Agreement").

Failure to sign and return the Agreement to CIGNA within 15 days of the date on the enclosed letter will result in the *immediate denial* of all short-term disability (STD) benefits.

I agree to reimburse EDS for any overpayment of disability income benefits I receive under the EDS Short-Term Disability Policy ("STD Policy"). I agree that, among other circumstances, an overpayment will arise to the extent I received benefits from the STD Policy that are: (1) either later determined to be payable to me under a Workers' Compensation law, an Occupational Disease law, Social Security laws, another similar law; or (2) paid pending the determination of a claim for STD Policy benefits which is ultimately denied. I authorize EDS to deduct any overpayment from my wages or any other benefits or payments that I may be eligible to receive, to the extent permissible by law.

I understand that EDS is relying on my statements and agreements herein as a condition of providing me with benefits under the STD Policy. I further understand that failure to reimburse EDS for overpayment of STD Policy benefits may result in disciplinary action, up to and including termination of my employment.

My signature below indicates my acceptance of the terms of this Agreement.

Employee's printed name (first, middle, last) _____ **Social Security Number** _____

Employee's signature _____ **Date** _____

Sign and return by mail or fax within 15 days of the date on the enclosed letter

CIGNA Group Insurance
EDS Short-Term Disability Team
Routing 212
12225 Greenville Ave.
Suite 1000
Dallas, TX 75243
Fax: 860-731-3511

File

File: Eligibility

Eligibility Information

:ile Information

Company Name:	ELECTRONIC DATA SYSTEMS (EDS)
File Date:	05/04/2004
File User ID:	GWU10017

:mployee Information

Employee:	HESTAL LIPSCOMB
Address Type:	HOME ADDRESS
Address Line 1:	3111 W. 2ND STREET
Address Line 2:	1ST FLOOR
:ity/State/Zip/Zip-Ext:	WILMINGTON, DE 19805
:ess Type:	WORK ADDRESS
Address Line 1:	5400 LEGACY DRIVE
Address Line 2:	
:ity/State/Zip/Zip-Ext:	PLANO, TX 75024 3105
:lient Location Code:	EDS01
:IGNA Location ID:	0000024765
:IGNA Work Structure ID:	0000005197
lome Phone:	REDACTED
Vork Phone:	
mployee#:	01071260
ate of Birth:	REDACTED
ender:	FEMALE
anguage:	ENGLISH
arital Status:	SINGLE
ax Filing State:	DE
ate of Death:	
andicap Indicator:	N
nployee ID Type:	SSN
ılary Mode:	ANNUAL
rnings Mode Code:	ANNUAL
rnings Amount:	$21,000.24
ork at Home Ind:	N
ward Ind:	N
ion Indicator:	N

LINA-032

Account Number:
SRO ID:
Div/Suffix:
SRO Cov Eff Date: 01/01/1901

nrollment Information - STD

Product: STD
Coverage Code: STD
Enrollment Effective Date: 01/01/2004
Enrollment Cancel Date:
Employee Paid Thru Date:
Account Number:
SRO ID:
SRO Div/Suffix:
SRO Cov Eff Date: 01/01/1901

overage Election Information - AR

Product: AR
Coverage Code: WCB
Benefit Description: AR (ABILITY RETURNS)
Provision Eff Date: 01/01/1901
Elected Benefit %: 0
Elected Benefit Count: 1
Elected Benefit Amount: 0
Contribution %: 0
Elected Effective Date: 01/01/2004
Elected End Date:
Tax Indicator: N
SML Coverage Code:

verage Election Information - FMLA

roduct: FMLA
overage Code: FMLA
enefit Description: FMLA-DISABILITY
rovision Eff Date: 01/01/1901
lected Benefit %: 0
lected Benefit Count: 1
lected Benefit Amount: 0
ontribution %: 0
lected Effective Date: 01/01/2004
lected End Date:
ost Tax Indicator: N
RO/SML Coverage Code:

verage Election Information - LTD

oduct: LTD
overage Code: LTD
enefit Description: LTD CORE
ovision Eff Date: 01/01/1901
ected Benefit %: 7
ected Benefit Count: 1
ected Benefit Amount: 0
bution %: 0
ed Effective Date: 01/01/2004
ected End Date:

LINA-033

Task | Contents | Notes (0/1)

Task: Intake

Start Date: 04/20/2004 **Due Date:** 05/03/2004

Details

Requestor Name	TRACEY EADDY				
Employee Name	HESTAL LIPSCOMB	Phone	(302)454-7622	Incident #	
Account Name	ELECTRONIC DATA SYSTEMS (EDS)	Phone	(302)655-8973	SS#	
		Claim Type	STD		

Requestor Information - Employee Information - Employer Information
Supervisor Information - Condition Information - Medical Information - Information from Employer

Requestor Information

Format	After Hours, E-Mail, Fax, Mail, Telephonic, Web				
Received Date	04/30/2004				
Role	Employer				
First Name	TRACEY				
Last Name	EADDY				
Phone Number	Type: Other Phone	Number: (302) 454-7622	Ext.		

Employee Information

SSN	S - Social Security Number	REDACTED	
Employee ID Number	MZ8S22		
Date of Birth	REDACTED	Age: 40	
Prefix Name			
First Name	HESTAL		
Middle Initial			
Last Name	LIPSCOMB		
Suffix Name			
Home Address	Added		
Address Line 1	3111 W. 2ND STREET		
Address Line 2	1ST FLOOR		
Zip Code	19805		
City	WILMINGTON		
State/Province	DELAWARE		
Country	United States		

	Type	Number	Ext.
Phone Number 1	Home	(302) 655-8973	
Phone Number 2	Work	(302) 454-7622	
Phone Number 3			
Phone Number 4			

E-Mail Address

Gender: Female, Male

Is Condition Related to Work Activities?	No
Claim Type	STD

Illness/Injury Information

Date Accident Happened or Symptoms first Appeared	03/01/2004
Past/Recurrent Condition?	Yes
Other Medical Conditions:	
Did Condition Result in Death?	
Time of Injury	
Body Section	
Side	
Body Part	
Nature of Injury	
Cause of Incident	
Place of Illness/Injury	■ Auto ■ Home ☒ Other
State Accident Occured In	
Describe What Happened:	
Place Description	
Address Line 1	
Address Line 2	
City	
State/Province	
Country	United States

Witness Information

Were There Witnesses?	

Medical Information

Hospital or Clinic?	No

Surgery Information

Surgery Scheduled or Performed?	Yes
Date of Surgery	04/29/2004
Type of Surgery	

Provider Information

First Name	JOHNATHAN
Last Name	KRAUT
Address Line 1	501 W. 14TH ST.
Address Line 2	
Zip Code	19801
City	

LINA-035

excluding holidays and vacation?

In the past 12 months, has the employee received any of the following?
- Attendance Warnings
- Performance Warnings
- Conduct Warnings
- Other

Hours Worked Last Day	8
First Day Missed From Work (ER)**	04/29/2004
Has Employee Returned to Work	No

Insurance Information

Healthcare Insurance Provider	Aetna
Life Insurance with Cigna?	
STD Effective Date	
STD Contribution	
Did the Employee purchase a Buy-Up Coverage for STD?	
Employer-Calculated Blended Contribution	0.00 %

Requested Job Description From Employer

Incident Number: 1191446

Comments:

Early Notice ID	000000000
CHC Eligibility Source	
CHC Data Source	
CHC Medical Product Type	
CIGNA Behavioral Type	
CHC Well Aware	Unknown

Last Changed User: Timothy Wilson Last Changed Date: 04/30/2004 08:26 AI

Active Contents

Type	Due Date	Created By	Assigned To	Name
STD	04/29/2004	Charlene Crowder	LIPSCOMB,HESTAL	REDACTED

itus: Completed Assigned To: Timothy Wilson Created